BED CHANGE REQUEST
State Form 52322 (7-05)
Indiana State Department of Health-Division of Long Term Care

Facility Number	Provider Number	Medicaid Number
Facility Name		
Facility Address		
City	Zip	County
Medicare Fiscal Intermediary		
Cost Reporting Year* * *Include the first and last days of the facility's cost reporting year*	Bed Change Effective Date* * *Facilities may affect a certified bed change once on the first day of the cost report year and once more on the first day of a singe cost report quarter*	

	Bed Classification Type	Current Configuration	Proposed Configuration
1	Non-Certified Comprehensive		
2	Residential		
3	Title 18 SNF		
4	Title 19 NF		
5	Title 18 SNF/19 NF		
	Total Certified (add lines 3, 4 and 5)		
	Total Licensed (add lines 1 through 5)		

Please include a completed SF 4332 Bed Inventory to reflect proposed configuration, and facility floor plan on 8.5" x 11" paper, to show room numbers and number of beds per room.

If facility is adding beds or converting beds from one level of care (residential, comprehensive) to another, the following may be required:

- Indiana State Department of Health, Division of Sanitary Engineering approval of architectural plans and specifications;
- Letter stating that construction is substantially complete;
- Life Safety Code, Sanitarian, and/or State Fire Code inspections, as appropriate; and
- Licensure fee for the addition of beds ($10 per bed).

Signature _____ Date _____